DEFENDANT'S EXHIBIT 278

Subject: ADM : PER : Adil Shafi : Personal Medical
From: Adil Shafi <adil.shafi@shafiinc.com>
Date: Thu, 30 Oct 2008 11:28:35 -0400
To: Heather Greenlay <HGreenlay@braintech.com>
CC: Rick Weidinger <rweidinger@braintech.com>, Barbara Shafi <barsshafi@aol.com>, Adil Shafi <ashafi@braintech.com>

Heather,

Attached is a medical bill that is not covered by our personal insurance.

As you know in August 12 Debt Schedule we had $8,616 allocated for Blue Cross Blue Shield (Row 51).

Our family personal insurance premiums are well below this total planned and the agreed plan was to use this as a budget for medical bills that would not be covered by personal insurnance coverage.

Also our personal insurance premium is due to be paid by Nov 1 or 2.

Your attention to this matter would be greatly appreciated.

Regards, Adil

Adil_Family_Medical_Oct_2008.pdf	**Content-Type:** application/pdf **Content-Encoding:** base64

From
BARBARA
SHAFI

Adil – Please scan & send bill to Heather. This is for Sarah's allergy blood test that is not covered by insurance.

Thanks. B

P.S. I forgot to give you the 1st notice, this is the 2nd

SAINT JOSEPH MERCY HEALTH SYSTEM
A MEMBER OF TRINITY HEALTH

St. Joseph Mercy Hospital
Saint Joseph Mercy Livingston Hospital
Saint Joseph Mercy Saline Hospital
P.O. Box 993 * Ann Arbor, MI 48106-0993

Remarkable Medicine. Remarkable Care.

Important Message

Your account is over 30 days past due. Payment in full is expected immediately. If this amount was paid, please disregard this message.

Payment Options- Pay your account by check or credit card over the phone by calling Customer Service or online (credit cards only) at SJMERCYHEALTH.ORG.

Payment Arrangements- We offer limited payment plans. If you cannot pay in full within 30 days, please call us. Making partial payments without contacting us may result in further collection activities.

C0-B-J-M-D
1V00557

[redacted]

Account Summary

Patient Name	[redacted]
Statement Date	10/26/08
Service Date	08/22/08
Type Of Service	Outpatient
Service Location	Reichert Health Center
Account Number	[redacted]
Total Charges	$ 493.00
Total Payments/Adjustments	$ 0.00
Current Account Balance	$ 493.00
Amount Pending Insurance	$ 0.00
Amount You Owe	$ 493.00

Insurance Information

We have billed the following insurances:
Insurance 1 BLUE CROSS MICHIGAN

Questions

Need help with your bill?- We have Customer Service personnel to answer questions. We understand that healthcare expenses are sometimes unexpected. Financial Counselors can assist with payment plans, help you qualify for public assistance programs and our own McAuley Support. Call (734) 712-3700 or (800) 676-0437 for more information.

Billing questions or changes in insurance coverage?
Please call Customer Service, Monday through Friday 8:00am to 6:30pm:

Local: (734) 712-3700
Toll Free: (800) 676-0437
Telecommunications Device for the Deaf
TDD (734) 827-9336

Please Note: Your physician may bill separately for their professional services.

TRINITYST1-1

SAINT JOSEPH MERCY HEALTH SYSTEM
A MEMBER OF TRINITY HEALTH

St. Joseph Mercy Hospital

REMARKABLE MEDICINE.
REMARKABLE CARE.

Statement Date: 10/26/08

Patient Name: SARAH GINA SHAFI
Account Number: [redacted]

Amount Due: $ 493.00
Amount Enclosed: $

☐ *Check here if your address or insurance information has changed. Please indicate changes on the back of this page.*

To pay by credit card: For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account number, and sign below.

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS

Account No. _____

Expiration Date _____ 48114

Signature X _____

Please make check payable to St. Joseph Mercy Hospital and send with this payment stub to:

SAINT JOSEPH MERCY HEALTH SYSTEM
P.O. BOX 371906
PITTSBURGH, PA 15250-7906

CCM03142695082351026200800004930O6

SAINT JOSEPH MERCY HEALTH SYSTEM

Patient Name: [redacted]
Account Number: 03[redacted]
Attending Physician: LEO, HARVEY

Patient Services Provided

[redacted]	$ 493.00
Total Charges	**$ 493.00**

For Your Information

Account Activity

DESCRIPTION	AMOUNT
Patient Payments	$ 0.00
Patient Adjustments	$ 0.00
Insurance Payments/Adjustments	$ 0.00

PLEASE COMPLETE IF YOUR ADDRESS OR INSURANCE HAS CHANGED

Address Change

RESPONSIBLE PARTY NAME | HOME TELEPHONE | WORK TELEPHONE

ADDRESS | CITY | STATE | ZIP

Insurance Update

POLICYHOLDER NAME | INSURANCE COMPANY NAME | GROUP POLICY PLAN NUMBER

POLICYHOLDER IDENTIFICATION NUMBER | CLAIM MAILING ADDRESS

POLICYHOLDER'S DATE OF BIRTH | CITY | STATE | ZIP

POLICYHOLDER'S RELATIONSHIP TO PATIENT | INSURANCE PHONE NUMBER

POLICYHOLDER'S EMPLOYER NAME | DATES OF COVERAGE EFFECTIVE FROM: | EFFECTIVE TO: